REPUBLIC OF GHANA

What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

NAVRONGO HEALTH RESEARCH CENTRE

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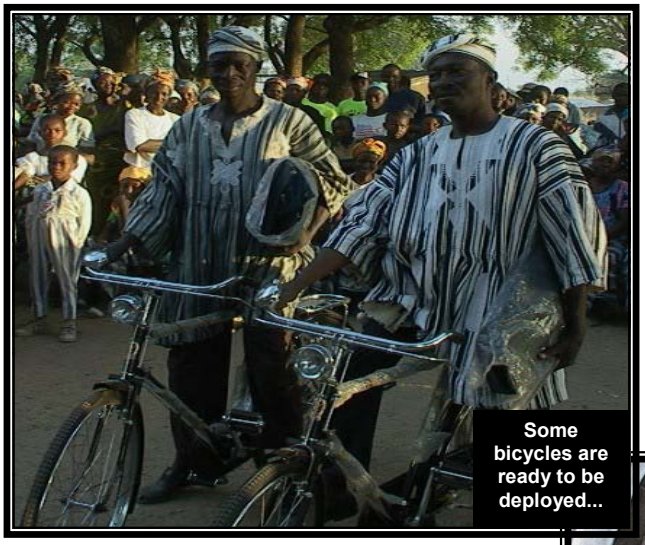
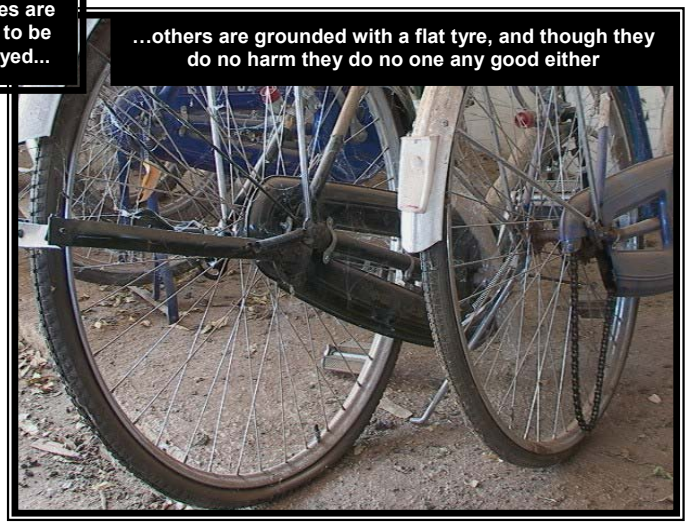
BICYCLE WITH A FLAT TYRE

This issue of ***What works? What fails?*** is based on NHRC report "Child Mortality and Health Seeking Behaviour of Primary Health Caretakers in the Kassena-Nankana District"[1]

In the Kassena-Nankana district, a volunteer on a bicycle symbolizes a new commitment to volunteerism that improves upon past failed programmes. Volunteers are equipped with bicycles, knapsacks, and basic drugs for treating minor ailments. Health committees provide supervision and leadership that were lacking previously; logistics operations ensure the regular flow of drugs through a sustainable programme of support for community leadership. Volunteers are trained and deployed, ensuring the best possible quality of care—with referral training to assure links to Community Health Officers (CHOs) and health centres. Community participation is developed with outreach to chiefs, training for councils of elders, and *durbars* for all. Taken together, this operation is called "The *Zurugelu*" approach to community mobilization. The operation works: volunteers are deployed, equipped, and appreciated; *durbars* occur in regular intervals, and health committees function as they should. Most international agencies, policymakers, and health providers believe that mobilizing community volunteer operations work will improve health.



Some bicycles are ready to be deployed...



...others are grounded with a flat tyre, and though they do no harm they do no one any good either

Results of the Navrongo Experiment challenge some of these assumptions. Success in getting volunteer bicycle wheels rolling may have failed to improve health. The bicycle initiative has a flat tyre that may be beyond repair:

- Children in the second year of life experience double the mortality rates that they experienced prior to intervention in areas where volunteers alone provide services,
- On the other hand, children aged 2 to 5 years experience about a third less mortality after intervention relative to rates before intervention in communities with a CHO. In the later years of childhood, the benefits are even greater —rates are roughly half pre-intervention levels.

These results indicate that the presence of the health volunteers (YZ) in the communities may be having a detrimental effect on child health. For example, the rise in mortality after YZ are posted could be attributed to the fact that when

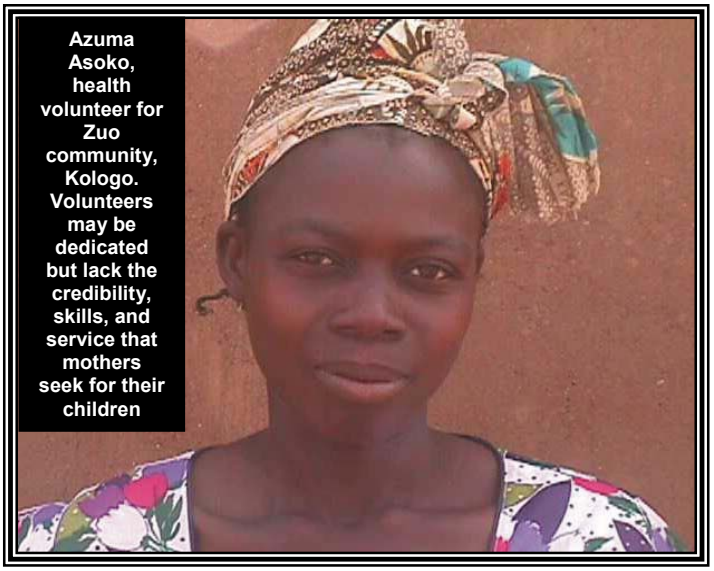
[1] Authored by Philomena Efua Nyarko, Rofina Asuru, Brian Pence, Patricia Akweongo, Philip Adongo, Joyce Ablordeppey, Abraham Hodgson.

children become sick, their mothers first consult the YZ (as the project intended), whose services are more convenient and less expensive than those of the clinic. As part of their responsibilities, the YZ are expected to provide basic medicines such as Paracetamol, and to refer children to a clinic for such things as antibiotic therapy. In the second year of life, acute respiratory infections (ARI) are an important cause of morbidity and mortality in the district. In such cases, mothers may be receiving ineffective treatment from the YZ rather than being referred to the clinic, leading to increased mortality among children in this age group. But, this is ruled out by training, supervision, and rules such as the one that YZ are not allowed to provide antipyretics to children. Research has determined that they are abiding by this rule. The second possibility is that mothers may not be responding to referrals by the YZ at all, or in situations where the mothers may heed the referral advice of the YZ, they may not treat it with the urgency that it deserves. Research turned to questions that could not be answered without investigation: Why is the CHO so much more effective than the volunteer? Why has the *zurugelu* approach failed to reduce childhood mortality when the nurse in the community works so well?

A study has shown that both nurses and volunteers are respected in communities, but nurses change traditional health-seeking behaviour while volunteers do not. Several important features of household health decisionmaking can lead to fatal delays in seeking effective care. For example:

- **Familial obligation diminishes mother's health-seeking autonomy.** Men, compound heads, and mothers-in-law have much to say about whether or not a sick child will be provided with health care. Only about a quarter of all mothers can make their own decisions about seeking health care.
- **Home treatment owing to resource constraints.** Most children are first treated at home, and many do not receive the appropriate care when this occurs. The cost of treatment is the main reason for delay in seeking formal health services.
- **Social customs cause delay in seeking treatment.** Mothers are expected to consult with husbands about possible supernatural causes of illness. Soothsayer consultation, herbal treatment, and other actions can seriously delay the process of seeking professional health provider assistance.

CHO have their impact on health by substituting services for these sources of delay. In cells where CHO are posted, women have more autonomy in seeking health care for children than in other cells. Accessible CHO services empower mothers to seek care for their children. Through household encounters, children receive prompt treatment that would require permission otherwise. Costs are reduced, and sometimes deferred, permitting families to share costs when resources are available. CHOs substitute modern services for traditional healing, providing a meaningful alternative to traditional care.



Azuma Asoko, health volunteer for Zuo community, Kologo. Volunteers may be dedicated but lack the credibility, skills, and service that mothers seek for their children

But the volunteer's bike has a flat tyre by comparison. Even the most dedicated volunteer lacks the credibility, skills, and services that mothers seek for their children. The health-seeking study suggests that they do no harm, but they do no real good either, apart from their role as family planning promoters among men, and their work as facilitators of CHO services. YZ do little to offset familial, resource, and social barriers to parental health seeking behaviour. Health volunteers should be community health promoters, not family health care providers.

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programmemes, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation. The Community Health Compound component of the CHFP has been supported, in part, by a grant of the Vanderbilt Family to the Population Council.